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Transferrable skills. You may have more to offer than you imagine

Chair Colin Hutchinson tells of his journey from Trust Clinical Director to local councillor and why local politics proves so fascinating

During a busy working life in medicine it's impossible to keep track of everything that you learn. Obviously, there is all the technical knowledge and the practical technique involved in examining and treating patients, but no less important are the skills that you develop in listening to patients and their families; the ability to explain complex problems in clear language; in assisting people to make difficult decisions; in weighing up the risks and benefits associated with any particular course of action, or inaction; and in building up trusting, professional relationships with patients, colleagues and others.

Sooner or later, most of us reach the point when we recognise that our ability to perform our chosen career has passed its best-before date and retirement becomes an attractive prospect – an opportunity to break free from the fixed commitments and responsibilities of clinical practice and develop other interests, maybe. At the same time, there may be pangs of regret that skills that have taken so much commitment to hone, will never again be put to use.

My retirement coincided with the disastrous general election of May 2015. After working in the NHS over 42 years, including 10 years as a Clinical Director for head and neck services, I had witnessed the way that the quality of service offered to patients fluctuated with the national economy and political ideology. I had experienced the exhilaration of building up services and contributing to the training of the next generation of clinicians, but the process of managed decline taking place under the banner

of austerity, the fragmentation and destabilisation of clinical services occasioned by the Health and Social Care Act 2012, all superimposed on the inadequate workforce planning and reduction of hospital bed capacity that had been going on for much longer, made me fearful for the continuity of the very services in which I and my colleagues had invested so much time and effort. It seemed I had two choices: I could either sit and throw things at the telly, growing bitter and twisted, or I could use my new-found free time to better understand what was happening, and see if there was any way to influence the course of events.

A successful beginning

My local acute hospital trust, and former employer, was taking forward plans to reconfigure services across its two district general hospitals, with one site becoming a planned care site and the other dealing with unplanned care, accompanied by a significant reduction in bed numbers and, supposedly, an expansion of the care that could be provided in the community. I was very aware of the difficulty of providing a full range of services across two sites, when it was proving impossible to retain a full complement of clinical staff, but I had particular concerns that the overall capacity of the reconfigured hospitals would be insufficient to meet the needs of the local population, nor could I detect any serious attempt to build up the capacity to deal with greater numbers of sicker patients in their own homes. The idea that, if you don't have enough doctors and nurses, you make the hospitals smaller, did not seem to make sense to me.

I joined other local campaigners in lobbying for a better solution in whatever forum was available, including meetings of the Clinical Commissioning Groups and local authority Health and Wellbeing Boards, as well as the Joint Health Overview and Scrutiny Committee. That committee eventually agreed with our main concerns and referred the decision back to the Secretary of State, who also concluded that the hospital capacity should not be reduced until such time as services in the community could reliably permit such a reduction.

If the original plan had gone unchallenged, the resulting hospitals would have struggled to an even greater extent than they did, to cope with maintaining services during the pandemic. It had taken 4 years, but we had achieved a result!

This experience showed me that it is possible to influence decisions, but that it can take concerted effort by many people over a prolonged period of time. Local campaigners really welcomed the contribution of a clinician. I provided a detailed understanding of the way in which the NHS works and the ability to distinguish weak from strong arguments. They provided enthusiasm, creativity and the experience of running an effective campaign.

I recognised the frustration of sitting in a 3-hour meeting, but only being able to deliver a 3-minute deputation and being unable to challenge statements that you know to be misleading, or just plain wrong, because you do not have the right to speak. Nevertheless, a well-crafted deputation can help set the tone for the rest of the meeting and prompt committee members to ask the right questions. But wouldn't it be better to be in a position to be asking those questions yourself? The only way to achieve that would be to become a member of that committee, which meant getting dragged into the murky world of local politics.

Into the fray

Having the opportunity to contest the electoral ward in which I had lived and worked for 20 years was a stroke of good fortune. I knew that during that time I had treated a lot of patients and worked with a large number of colleagues, but I hadn't appreciated how many of them I would meet over the months of the election campaign. I was just relieved that I hadn't been rude to too many of them! It was a strange experience to

"The only way ... would be to become a member of their committee, which meant getting dragged into the murky world of local politics."

begin with, to just knock on a stranger's door and introduce yourself, but there are quite a few similarities to the skills needed for an outpatient consultation – encouraging people to speak to you, establishing any particular causes of concern, and exploring the approaches that could be taken to try

and address those problems, and trying to show that they could trust you to represent their best interest. Of course, as in medicine, not every problem can be resolved and it is important not to raise expectations that you are unable to fulfil – most people respect candour. Nevertheless, you can't expect anyone to be bothered to vote for you unless you can convince them that you will do your utmost to change at least some aspect of their lives for the better. Negative campaigning simply encourages hopelessness, or cynicism (a plague on all your houses) and a sense of powerlessness, which can push people to look for more extreme solutions to the problems they are experiencing.

Against the national trend, in 2018 I became the first ever Labour councillor to represent my ward. Now there are three of us contributing to Calderdale Council coming under Labour majority control in 2019, for the first time in 20 years. Would I be able to do any of the things I had

hoped? Would it be worth the hours and days of bothering people on their doorsteps?

A different kind of environment

I had anticipated the sense of disorientation in suddenly having to find a way around a large and unfamiliar organisation – not very different from taking up a new post in the NHS, although there wasn't the same expectation that you would hit the ground running and less dread of causing harm through ignorance. There was a pretty good induction programme for novice councillors and ongoing training. I took full advantage of playing the naivety card to ask questions about how the organisation really worked, and, much like in the NHS, understanding which officials had the talent of solving problems, and which would only respond to pressure from their line manager. I find asking officers to tell you about their job can open a lot of doors. There is a misunderstanding amongst the public, that elected councillors have the power to order unelected officers to do things. That is definitely not the case. Councillors decide the policies that guide the work of Officers and how the available budget is allocated between the different departments of the Council, but beyond that, Officers have considerable discretion as to how they carry out their role, and are bound by the law, much as Civil Servants are in central government. We can, however, encourage Officers' interest in particular cases, show an interest and try and understand their particular area of work and, if all else fails, resort to nagging, depending on the individuals involved – again, no different from working in the NHS.

I was also blithely unaware of the true scope of responsibilities that fall to local government and the specialist knowledge and skills of so many of the officers. It isn't all about parking and dog poo, important though they are. The services that have an impact on almost all residents, such as household waste collection, street cleaning and care of public spaces, tend to be the benchmark



against which most voters assess the performance of their local authority. By contrast, social care for children and for adults with disabilities is a legal and moral responsibility and accounts for two-thirds of the council's revenue budget, but only directly impacts a small number of residents. The brunt of successive governments' austerity programmes have fallen on local government, halving the council's revenue budget in real terms. We have to provide social care to the most vulnerable in society, so the cuts have been disproportionately severe on youth services, libraries, children's centres, sports facilities, parks, street cleansing, museums, social housing, town and country planning, building control services and community safety teams.

So many of these activities have an impact on public health and wellbeing, particularly for the less advantaged in our communities. In Calderdale there is already a gap of 14 years in the healthy life expectancy of males and nearly 16 years for females, between the most and least deprived wards and the gap is widening. There is no sign of turning this around any time soon, without a radical change in attitude to public services, an understanding that inequality has negative impacts on the whole of society and an appreciation that our future prosperity will depend on the creativity, skill and hard work of a healthy, well-educated population. Why are we so reluctant to make those investments?

You do come across residents who are convinced that corruption taints decision-making, particularly

in the area of planning and development. I am pleased to say that I have come across no evidence of this in the four and a half years I have served. I have seen no sign of brown envelopes, or carrier bags of used notes changing hands. And it really doesn't feel like we're riding the gravy train, with an annual allowance of less than £11,000, unless you have a cabinet position, and there is a huge increase in time commitment that goes along with that enhanced allowance. I am in the fortunate position of having the security of an NHS pension, but I can understand why many younger people feel they cannot afford to consider becoming a local councillor, unless they are hell-bent on a career in politics.

With a few exceptions, I have been pleasantly surprised at the ability of elected councillors from across the political spectrum to work collaboratively and constructively. Most are pragmatic people, seeking the best for the residents they represent, and keen to find practical solutions to practical problems. Most agree that local government could deliver much greater benefits, if only there was a better balance between local and central arms of government. Most agree that our current system of funding local services through Council Tax and Business Rates does not meet today's challenges and is in urgent need of reform. Of course, there is the occasional pantomime of meetings of the full council, where political differences tend to be magnified for dramatic effect, but as at Westminster, most of the work takes place in smaller, cross-party committees, scrutinising the effectiveness of services delivered by the local authority and other public bodies, including various NHS organisations, and that was where I hoped I could use my previous experience and make the greatest difference.

Since 2001, local authorities have had a duty to

monitor the planning and delivery of health and social care services provided to their residents in a public and transparent way. When some of the responsibility for public health was passed onto local authorities, this also came within the remit. To enable them to fulfil these functions, councils are required to establish Health and Social Care Overview and Scrutiny Committees which have the power to require NHS, local authority and other providers of health or social care to produce evidence, attend meetings and respond to written requests and reports. The meetings are expected

“Many of the bodies were presenting their evidence ... not written in plain English but full of jargon and acronyms... ‘management speak’.”

to take place in public unless there were truly exceptional reasons to deny public access. These powers and duties were strengthened following the Francis Report: their role as a channel through which the public could raise concerns was stressed, emphasising that these committees had a duty to

collate complaints from the public and investigate any patterns or trends emerging. Responsibility for investigating individual complaints rests with other statutory bodies.

These committees have a duty to investigate any substantial variation of services that might be proposed, such as the hospital reconfiguration plans mentioned earlier, or ceasing the provision of a particular service at certain hospital sites. If the scrutiny committee decides that the proposal is not in the interest of the local population, or if there has been inadequate consultation, the committee has the power to refer the matter to the Secretary of State for their consideration, which can involve considerable delay in implementation, or even rejection of the planned change. It is therefore in the interests of the NHS to work closely with these committees in the formative stage of any major developments. If changes are brought forward that affect the residents of more than one local authority, they can set up

joint committees to scrutinise and report on the plans. I have sat on the committee considering the hospital reconfiguration plans for the past 4 years as revised plans, this time without any reduction in bed numbers (but without any increase either; despite the demographic changes in the local population, with larger numbers of people in older age groups). It is 9 years since this process started and there are still concerns that inflation of building costs could see us ending up with hospitals that are too small for the needs of the population, but we are monitoring the situation carefully.

The first few meetings of the health and social care scrutiny committee that I attended gave me some concern. Many of the NHS bodies were presenting their evidence to the committee in reports that were not written in plain English, but full of jargon and acronyms. It was hard to tell whether this was deliberate obfuscation, or simply reflected the 'management-speak' that had pervaded the NHS hierarchy. The effect was to make many of the reports almost unreadable, with the result that most of the subsequent questioning was devoted to clarification of the report, rather than its wider implications. There was a very definite asymmetry of knowledge, making councillors reluctant to ask challenging questions, through lack of confidence. Having spent 10 years as a Clinical Director, I was well used to reading turgid, long-winded waffle. I might even have written some myself, but I am trying to break the habit! I had developed a good working knowledge of the way that the NHS worked and many of its weak points. I felt I had a reasonable understanding of what was being said and, crucially, what might have been left out. It seemed perfectly reasonable to flag up areas where further information was required and to request it be produced at subsequent committee sessions.

Over the course of a few meetings, I was pleased to see that the evidence that was being presented became clearer and more concise as NHS colleagues came to understand what was being expected of them. They have come to expect that

we will seek corroborating evidence from other sources. The need to request supplementary reports reduced. Fellow councillors developed the confidence to challenge the evidence that was being presented, and ensure that it should be understandable to the general public. The quality of the discussions improved and the dialogue became more constructive. There was no shortage of critical observation, but the emphasis was usually on finding solutions to improve outcomes for patients. These improvements have not taken place across the board – there are areas of mental health, primary and community health services that are still very much work in progress.

As well as regular review of the social care service, the adequacy of safeguarding measures, and reviews of complaints received, we have considered matters as diverse as access to dentistry, the strategy for dealing with homelessness, assessment and support for people with neurodiversity and the local implications of the Ockenden Review into maternity services. A particularly wide-ranging programme of work stemmed from the deaths of five homeless men on the streets of Halifax in the winter of 2018-19. All were leading street-based lives. All were known to local health and support services, as well as to the police. Nobody took overall responsibility for their wellbeing. Their irregular lifestyles meant that they did not fit into an inflexible system dependent on appointment times, virtual services and 'signposting'. Signposting seems to have become extremely common in services relating to mental health. Patients are informed of services that might be appropriate for their needs, but are given the responsibility to select and make contact with services, rather than being formally referred to them. The responsibility rests with the patient / client / customer, rather than with the professionals making or receiving the referral. If they don't follow the signpost, nobody is any the wiser: nobody enquires why they haven't shown up.

The 'Burnt Bridges' report [1] that resulted from this inquiry made for very uncomfortable

reading, but has prompted a major change in approach to supporting people with complex needs, including ensuring access to primary and community care in a more accessible location, based on an understanding of the traumatic events that have shaped the lives of many such people, and with closer communication between the various services with which they come into contact and an emphasis on continuity of care. The experience that has been gained in different parts of the country, including Middlesbrough, Glasgow, Bristol and Thames Valley, with approaches to reducing harm from drug and alcohol use, rather than relying on the criminal justice system, is starting to be applied [2]. When fully developed, this will probably include access to heroin-assisted treatment, confidential testing of on-street drugs for composition and purity, and exploring the issues underlying drug use, and addressing them, rather than an automatic resort to pressing criminal charges. There is a good base of evidence to support each of these approaches. The scrutiny committee continues to play a part in following through the recommendations of this report, supporting the people delivering the change, applying pressure where needed and monitoring the outcomes. It also has a crucial role to play in helping the public understand that change is taking place, and why.

Throughout the first 2 years of the Covid pandemic we received monthly updates on the local response, including the coordinated support for care homes and homecare services, local contact tracing, the vaccination programme and the state of hospital and community services. It was seen as important that these reports were in the public domain, to maintain appropriate levels of confidence and reduce rumour and speculation. We also held a 'scrutiny in a day' exercise, in October 2020, to try and capture the experience from the early response to the pandemic, while it was still reasonably fresh in people's memories, and support the preparations for the approaching winter.

Integrated care

Reorganisation of the English NHS into Integrated Care Systems (ICSs) has made it even more important to scrutinise the planning and delivery of health and care services at ICS level and the West Yorkshire Joint Health Overview and Scrutiny Committee has been working with the shadow partnership board for 2 years as their plans have developed. We wrote to the Secretary of State, representing the views of the five local authorities of West Yorkshire, in response to the consultation on the Integration and Innovation White Paper, including concerns that no provision was being made for robust workforce planning at ICS level and the potential for profit-seeking companies to be in a position to shape the design of services to suit their preferred business models. It was hard to find evidence that our concerns had been registered.

More recently we have scrutinised in detail the draft constitution of the Integrated Care Board (ICB). We took the opportunity to make constructive criticism to the highest level of the shadow ICB. This time, our concerns were reflected in a number of changes in the final constitution [3]. These included the statement that the purpose of the ICB is to secure the provision of a universal comprehensive health service; that this service will cover people both from outside West Yorkshire who need care while they are in the region, and people from West Yorkshire who need care while visiting other parts of the country; and that there should be a People Committee, which publishes its minutes, so that we can hold them to account through scrutiny. We are very aware of the need to ensure that the ICB seizes the opportunity to develop and maintain its own workforce strategy: a population of two million people should be a large enough base from which to 'grow our own' workforce for most of our local needs, rather than being dragged down by failures of central government to take the issue seriously.



Inability to recruit sufficient specialised clinicians to provide a safe service has repeatedly been the stated reason to centralise services, usually in either Leeds or Bradford, withdrawing provision from the various district general hospitals serving the other large towns of the West Riding, with a reduction in the attractiveness to enthusiastic young doctors of a career in DGHs, a reduction in the breadth of diagnostic expertise and other skills outside specialist centres and an increased need for patients and their family to travel much further to receive care previously available to them locally. As one service is withdrawn, there are often unforeseen consequences which can produce a domino effect, destabilising other services. Over the past 4 years, we have had to consider reconfiguration proposals for stroke services, vascular surgery, non-surgical oncology and child and adolescent in-patient mental healthcare provision. It is difficult to argue with colleagues when they tell you that they are losing the struggle to run a safe service, because of inability to attract sufficient staff, but too often the solution seems to only provide a temporary respite. Without an increase in postgraduate training places and measures to improve staff retention, we are likely to be asked to centralise the same services to an even greater degree in a few years. We did manage to secure additional radiology postgraduate training places, as a condition for agreeing reconfiguration of vascular surgical services, where the key factor was a lack of interventional radiologists and will be seeking similar terms where new proposals are made for significant variations in service provision.

The interconnectedness of all things

Through much of my life I have had flashbacks to situations in *Catch-22*, *Slaughterhouse 5*, *Hitchhiker's Guide to the Galaxy* and *Gravity's Rainbow*, but Douglas Adams' description of "The interconnectedness of all things" increasingly rings true as I take on new responsibilities within local

government and I am brought unusual casework by local residents. The work is so much more interesting and much more varied, than I had anticipated and there is just so much to learn, but experience in one area keeps making itself relevant in a seemingly totally different sphere. The response to the pandemic, the declaration of a climate emergency and Sir Michael Marmot's work on the social determinants of health have really brought this interconnectedness home to me. Even something as apparently dry as representing Calderdale on the Parking and Traffic Regulation Outside London Adjudication Committee (PATROL) develops a fascination when you dig a bit deeper: PATROL administers the appeal system for people challenging parking tickets. They operate a cheap, fast and effective online system of justice, which is responsive to the needs of the person lodging the appeal, offering hearings online, by phone or by video-link, with access to whatever legal representation meets the needs of the appellant. Most cases are concluded within 4 weeks, all funded by 45 pence out of the cost of each penalty notice awarded, a figure that has remained unchanged for several years. There must be scope for something similar to be rolled out to other areas of our log-jammed justice system! But PATROL also works to assist the drafting of legislation and helping local authorities implement: charging clean air zones; the introduction of low-emission vehicles and the required charging infrastructure; the introduction of autonomous vehicles to our roads, so the

implications for climate change and public health become immediately apparent.

I represent my local authority on the local government pension scheme, which controls nearly £16 billion of investments at West Yorkshire level. Across the country it amounts to the fourth largest pension fund in the world. Although it is vital to ensure the financial stability of current and future pensioners, there are legal obligations also to consider environmental, social and governance implications of the investment policy and the potential impact of those investment decisions, for good or ill, on climate change, biodiversity, environmental degradation, the arms industry and human rights.

I am also a member of the Planning Committee, which considers the merits of planning applications that officers of the Planning Authority feel are particularly sensitive, or where planning policy does not give sufficiently clear guidance for officers to determine planning permission. Under these circumstances, the decision is taken by a committee of elected councillors using their individual judgment, within the framework imposed by national planning law and local policies. I enjoy this committee – it actually takes decisions and the impact becomes visible and solid pretty quickly, as the building begins to rise (or doesn't, if permission has been refused). Planning has such scope to produce great homes and neighbourhoods in which to grow up, or start a family, or enjoy your third age. It can help people with disabilities to lead as full and independent a life as possible, participating in wider society. It can help reduce isolation and loneliness and reduce our dependence on fossil fuels. It has the potential to build strong communities; done poorly it can break them apart.

As a member of Calderdale's Climate Change Committee, I am involved in developing and promoting our emissions reduction pathway, and action plan to ensure we meet our target of reaching net zero by 2038, with substantial progress by 2030. Minimising climate change and

mitigating its worst effects are the biggest public health challenge we face. There are few aspects of our lives that will remain unchanged, but there are plenty of opportunities to build a better, fairer and healthier world, if we approach this task with those goals in mind. We know what needs to be done; we have most of the technology we need; we just need to ensure the political leadership is up to the job and immune to lobbying by the rich and powerful.

We will only get good leaders if good people put themselves forward. The skills you developed to help people as a doctor are a great foundation for continued involvement in your local community. For me, it has opened up a whole new range of interests, given me a much greater appreciation of what goes into making a community work, strengthened my ties to the place I live and given me scope to continue to use the knowledge and training accumulated over the years of clinical practice. Don't just sit and fume! And certainly don't give up hope! You may have more to offer than you imagine.

References

- [1] Cullen, N. (2020) Burnt Bridges? A Thematic Review of the deaths of five men on the streets of Halifax during Winter 2018/19. Calderdale Council. Available at: <https://bit.ly/3RZXU2k>
- [2] Transform Drug Policy Foundation (2022) Changing lives, here and now. Our programme of local reform work is vital to reducing drug harms today. Transform. Available at: <https://bit.ly/3Oucxlg>
- [3] NHS West Yorkshire Integrated Care Board (2022) Constitution. Available at: <https://bit.ly/3S3VklP>

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Notice: AGM and Conference 2022

This year's AGM and conference will be held on Saturday 1 October at:

The Royal Society of Medicine
1 Wimpole Street
London
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11 am to 6 pm

As in recent years, you will be able to attend 'in real life' or virtually via Zoom. We hope you elect for the former as we haven't seen much of each other for several years, but attending 'down the line' is also very much welcome.

List of speakers and full booking details will be sent to members next month. But make a note in your diary now.

This is a critical time for the NHS, as successive undermining by governments has weakened it to the point where the crisis in workforce planning is now being openly discussed (see below). This is something we, and groups like us, have been warning about for years. No surprises then, but there is much to do and much to save. Come to the AGM to hear more, and put your point across.

Report on Workforce Planning: yes, it really is as bad as it can get

The Report, *Workforce: recruitment, training and retention in health and social care* (see <https://bit.ly/3cMfaYY>), by the House of Commons Health and Social Care Committee, will come as no surprise to anyone reading this newsletter but it may surprise some to learn that one of its principal authors is none other than Jeremy Hunt, MP, who as Health Secretary had the dubious distinction of antagonising large numbers of doctors in training.

The Report echoes what health campaign groups have been raising the alarm about: a lack of workforce planning, recruitment and retention in the NHS are the greatest in the NHS's history, and the government is not acting to do anything about it. Better late than never? This should have been acted on years ago. But it is a relief to finally see it admitted to.

A Sinking Cornerstone: The vanishing of personal continuity of care

Like a nearly extinct species, the value of personal continuity of care is, at last, receiving some eleventh-hour anxious attention, at least from some healthcare academics and journalists. The clear benefits to patients are recognised. Hardly ever, though, are the benefits to healthcare workers mentioned. Here is a short redress.

“Cornerstone: a foundation-stone; an indispensable part or basis of something.”

— *Oxford Concise Dictionary*

“It is as important to know what sort of a patient has a disease as what sort of a disease a patient has.”

— William Osler MD, 1849-1919

In the mid-1970s, when I first became a Principal GP, personal continuity of care was regarded as a *sine qua non* of most good practice. We may not have spoken much about it, but we recognised that in all but the most simply and rapidly fixable of conditions the science of any treatment was likely to be far more apposite, accurate and effective when delivered together with the personal art of practice.

What is this art? And why has it disappeared? It will be clearer to answer these questions separately.

The art of medicine used to refer, mostly, to the skilled personal understanding, resonance and attunement a doctor brought to a consultation. It was about the often nuanced, sometimes unspoken, incorporations of personal and social context and subtext. It required empirical human imagination quite as much as fact-based deduction.

Personal continuity of care could then weave together the more measurable and objective aspects of science with the less measurable (inter-) subjective and meaning-laden aspects of art. This weave, it was believed (accurately, as we will see), is often powerfully effective. By offering comfort, containment, personal understanding and accurately judged support and guidance, many therapeutic benefits followed: patients' symptoms were often lessened or became more endurable, their morale and mood stability much improved, compliance to prescribed treatments became more unproblematically positive, exacerbations and deteriorations of conditions lessened...

So we understood this: that procedures or drugs can treat, but it is the personal relationships and understandings that heal. Clearly, we need both.

Before the serial 'modernising' reforms – say pre-1990 – general practice was served by much smaller units with long-term staff stability and little micromanagement by executive agencies. These erstwhile GPs and their colleagueial healthcare workers (eg District, Practice and Community Psychiatric Nurses, Practice Counsellors etc) were far more likely than now to know both their patients and their colleagues.

Many practices and practitioners were mindfully respectful and protective of this cornerstone of personal practice – the importance of personal bonds and relationships – which themselves often seemed guided by maxims of belief and faith.

‘The more you see of someone, the more of someone you see.’

and this one too:

**'Medicine is a humanity guided by science.
That humanity is an art and an ethos.'**

Yet we had little proof of such articles of faith.

Data-based, quantitative research into personal continuity of care became much more substantial in the last 30 years as computer use became all-but universal: obviously computers are now essential for any big-data studies. Such studies were previously well-nigh impossible. But there is a dark synchronicity here because just as we became able to statistically evidence and prove the positive effects of personal continuity of care, that form of care was, at the same time, rapidly perishing. Coincidental with computerisation were the 'modernising' reforms: the closure of small practices (and hospitals), the abolition of GP personal lists, the delegation of out-of-hours services and the vanishing of consultant-led 'firms'. These reforms were to be modelled on competitive manufacturing industries – therefore, wherever possible, to cut down, to scale up, standardise, automate, corporatise and commercialise [1]. There is hardly any place in such reforms for considerations of personal context or subtext – therefore for personal continuity of care. Relationships are then rendered irrelevant or redundant; instead the healthcareers are corralled by a regime of no-one-knows-anyone-but-just-do-as-you're-told-and-follow-the-algorithm.

The history here shows us a rather tragic paradox – amidst this mounting depersonalisation and industrialisation of healthcare has come recurring and mounting evidence of the measurable (not just the experiential) benefits of personal continuity of care: better control of chronic physical conditions (eg Cardiorespiratory, diabetes); fewer A&E attendances, acute hospital admissions and mental

health crises; fewer serious prescribing errors; and (most remarkably?) greater longevity [2].

So personal continuity of care (most easily delivered in vanishing smaller practices) is likely to be not only more comforting, but better for your health. And there's a high chance you'll live longer.

Much belatedly now, just as this cornerstone of wise and compassionate practice is sinking into extinction, there is patchy recognition of, and interest in, the vanishing benefits of such personally infused and tethered medicine [3]. The hazards and costs to patients of extinction of such care are also referred to.

What is much less referred to or researched – if at all – is the benefit to the healthcare practitioner in giving such care. Erstwhile smaller practice

**"Among GPs
recruitment is now
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family doctors (remember them?) were a much more stable and professionally fulfilled workforce than the 'primary care service providers' (aka GPs) we have now. That is because such smaller practices were a far easier, more natural, habitat for any personal continuity. So those more fortunate doctors relatively healthy and happy working lives then were rooted in – and drew

sustenance from – the personal identifications and relationships they could grow with their patients and co-workers.

Yes, there has always been an intellectual buzz to be had from making an accurate major diagnosis or successful intervention. But most of those not-yet-reformed GPs were probably sustained and nourished far more by the relationship aspects of work: the growing understandings, trust, shared experiences and affectional bonds that grew from their caring encounters.

Cumulatively these spawned to grow into valued senses of community for both patients and doctors.

Our modernised regimes have lost sight of

something crucial: doctors who find more human sense, belonging and fulfilment in their work are, almost certainly, able to provide better care. But our serial reforms – in an imperative push to commodified-industrial type of managed facility, efficiency and cost savings – have disregarded, then abandoned, a time-honoured cornerstone of practice.

Without this cornerstone our NHS edifice is destabilised: it first tilts and cracks ... these are premonitions of collapse. The tilting and cracking is now signalled by the growing discontent we see among patients and doctors. Among GPs recruitment is now parlous; unprecedented burn-out, breakdown, drop-out, sickness, drug and alcohol abuse, earliest retirement all imperil a previously (relatively) robust and stable workforce. Often painfully avoided are mentions of the increasing suicides.

Such is the price of abandoning our human cornerstone to pursue industrial and commercial 'efficiencies'. Surely, any such gains are a pyrrhic victory.

References

[1] Zigmond, D. (2019) *The Perils of Industrialised Healthcare*. The Centre for Welfare Reform. This provides a brief and accessible overview of the nature and thinking behind thirty years of NHS reforms and their current consequences and predicaments.

[2] There is now much solid research demonstrating the benefits of personal continuity of healthcare, especially in general practice. Perhaps the most comprehensive and long-term work has been done by a team at Exeter University, headed by Denis Pereira Gray. See especially: Pereira Gray, D., et al. (2018) 'Continuity of care with doctors – a matter of life and death? A systematic review of continuity of care and mortality'. *BMJ Open*.

[3] See, for example 'Falling NHS Continuity of care poses "existential threat" to patient safety.'



Guardian, 23 June 2022, reporting on a conference speech at the Royal College of General Practitioners.

Many articles exploring similar themes are available on David Zigmond's Home Page (<https://bit.ly/32N4jcd>)

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Book Reviews

NHS Under Seige: The fight to save it in the age of Covid

(£9.69, Amazon, paperback)

John Lister and Jacky Davis. Merlin, Dagenham, 2022, 290 pp.

As you should expect from these authors, the most striking first impression of this, their latest book, is the wealth of data supporting their arguments.

Number after number after number; none of them boding well for the NHS unless drastic action is taken, and the authors go into some detail as to how they think this might be done. Hundreds of figures underpin and define the points put forward in this book, showing time and again that this is as grounded in reliable figures as it is aspirational in its aims and damning in its analysis of just how one of the world's most developed nations has managed to mis-govern the people's health so completely. To be plain, that means only one thing: too many are dead who need not have been, and too many of those still living are suffering needlessly. Simply because of political choices grounded in an ideology which is both hostile to the principles underpinning the NHS and blind to the grave consequences of that hostility.

The book is structured chronologically, charting the deliberate degradation and undermining of the NHS from the Cameron era and austerity years, leading up to and beyond the pandemic – or, at least, the waves of it we've experienced to date. We read about the ocean of cutbacks to funding and lack of investment that defined 2010-19, reflected in Lansley's great misconception, the Health and Social Care Act, with wave after wave of 'efficiency savings', the attempted workaround that was the *Five Year Forward View*, the emergence of the Sustainability and Transformation Plans (STPs) and their later iterations; May's offer of 'extra' funding that went nowhere close enough to make up the years of austerity, and the folly of Johnson's false promises over Brexit and the



NHS. So the start of the pandemic saw the NHS with almost 9,000 beds fewer than in 2010 and waiting lists growing from 2 million to 4.5 million.

The chapter chronicling the pandemic itself is the most hard hitting. Not surprisingly, public services could not cope. The authors state avoidable deaths from Covid, because of this appalling lack of investment, stand at over 180,000. They then go into how the government failed to protect the vulnerable, showed time after time that it was prepared to accept deaths to protect the economy, and – dominating this landscape of wilful neglect and gross incompetence – how massive and massively corrupt investment in private companies instead of experienced public-health teams saw billions thrown at the folly of Test & Trace, as manifest a failure in governance as anyone could hope to dream up. Only it was

all too real – and countless lives were lost and incomes robbed as a direct result. All the time, with no sign of any attempt at government accountability and to date no sign of any formal Inquiry. The authors acknowledge the work done by the People's Covid Inquiry, in virtuous contrast to the government's continued exercise in denial. I would like to say I hope the change of leadership changes that. But no one should expect to hear anything like that soon.

Nor, it would seem, anything like a change of tune over austerity. The beast is back, as red in tooth and claw and as mean in spirit as ever. Only now, thanks to how the pandemic was not handled, the NHS is even more weakened, to the point where it has an inbuilt *dependence* on the private sector. Which a later chapter covers in more detail.

You might have thought that was all part of some dystopian plan...

So we hear of yet more futile cycles of impossible targets heaped on NHS trusts, threats of sanction if they 'fail' to meet them, the imposition of forced discharges that by any reasonable reckoning would be seen for what they really are – reckless abandonment, adorned with empty promises of 'high-tech innovation' which simply leaves vulnerable people at greater risk. Triggered by the ongoing decline in services, as demand after the pandemic increases with around 110,000 staff vacancies, with roughly 25 per cent of acute bed capacity pre-pandemic (hardly a ringing endorsement for a starting point in itself) left empty or filled with Covid patients. Which, surprise, surprise, is stubbornly immune to the effects of government denial and refuses to go away. What can you expect from a government which could even entertain for a second the notion that 'booster vaccinations will mean cuts'? Yet there it is, plain as day. Cutting costs, clearly, means more than stopping lives cut short. Then there are the growing crises in maternity care, emergency care, cancer care, ambulance response times – more and more examples which only add weight to the case to take action. The final chapter

gives a short history of health campaigning in the UK to show how it has worked, can work, and must work again.

The last section of the book is devoted to specialist contributions, which add further dimensions to the arguments put forward by the authors earlier. There are 13 of these, far too many to review adequately here, so I will illustrate with just a few – a completely personal choice.

Michael Marmot takes a guest chapter, spelling out how health inequality has risen because of all this, and how the pandemic made things far worse.

Marin McKee's short chapter also adds a useful overview on how the UK fared with Covid (badly, but the NHS responded remarkably well despite the foregoing years of neglect).

Neena Modi's chapter on the treatment of children in the pandemic makes the point that early assurances about children 'not being so vulnerable to infection' have been overshadowed by the worsening indicators for mental health and education, as well as little research funding for children. Roy Lilley's easy narrative style belies the serious message in his chapter, which is that without workforce planning all of the elaborate plans now being furnished will amount to nothing even if they had the funding. Which they do not.

About the only criticism I can muster is, the book should come with a health warning. If you have a shred of decency and an ounce of conscience, if you have even the slightest leaning towards the belief that a health service should treat all in need for the good of all, this book will annoy you. You will find that anger fuelled by every careful analysis. It should make you want to stop what is happening – which is one of the book's declared principal aims. Of course I recommend this book. But don't take my word for it, check for yourself. Be angry.

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How the NHS Coped with Covid-19

(£15.99, Amazon, paperback; £5.59 Kindle)

Ellen Welch. Pen & Sword, Yorkshire, 2022, 208 pp.

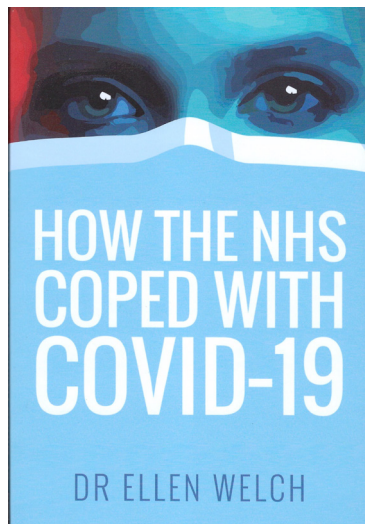
Ellen Welch, as a GP, spent the pandemic working from her home in Cumbria for an out of hours NHS provider and is still based in Cumbria as a GP.

This gives her telling of how the NHS coped with Covid-19 a particularly keen edge. She worked the pandemic very much on the front line. As one of Doctors' Association UK's editorial team she was also very well placed to judge how many of her colleagues in hospitals and practices throughout the UK were faring. This book therefore taps an impressively deep well of anecdote, drawn first hand, from medical and health professional colleagues, as well as offering a month by month timeline of the pandemic's progress from the very last day of 2019 through the whole of 2020, in which the key public milestones, statistics and political decisions are mapped.

This narrative counterpoint lends the book a strength which the gruelling statistics, of which there are plenty, might struggle to demonstrate. For example, the poignant account written by Ines Fernandes Antunes who worked as a cruise ship nurse, as the first personal anecdote, portrays the particular difficulties faced by crews aboard ships in the early days of the pandemic, leaving many crew stranded on board for months – ironically well in excess of the '40 nights' from which the historical origins of 'quarantine' is itself derived: "We were unable to step foot on land, unable to hug anyone, even going to the bathroom in full PPE was a nightmare".

As the pandemic gained a foothold then swept largely unopposed through Britain until lockdowns were forced on us, far too late, the breadth and numbers of health professionals drawn into trying to cope also grew.

So we learn about the East Midlands paramedic, who tells us: "We took Debra [one of her first Covid patients] to hospital – she said goodbye to her partner as we wheeled her onto the ambulance, and I still wonder now if they ever saw each



other again. This would become a regular heart-wrenching scene for all our patients".

But, a common theme throughout the testimonies given by NHS staff, there is hope: "This pandemic has brought out the best and worst of people... people stopped and waved at us in the street, gave us food ... and were so thankful and grateful for everything we were doing".

The 'Intensive Care Covid diaries' run throughout the book and not surprisingly shed a lot of light on what it feels like to work in an ICU throughout the pandemic. "I know a lot of doctors are very scared", to "We're beginning to know this silent enemy", "It is getting harder to switch off from work", and "I call the family of an 80-year-old man. His wife tells me she is a nurse of 35 years... I promise her I will deliver a message to him... I do ...2 days later, he passes away on the ward, having seen his family for the first time" are a very few examples of this stark and detailed account.

The account critiquing the 'NHS Heroes' meme so shamelessly injected into the public domain by a government which ensured the NHS was grossly

unprepared for the pandemic (see the review on Page 16) is uncompromising in revealing the true political agenda behind this act of expedient lionisation: distraction (from the real causes) to denial (go back into the shadows, as all superheroes do, you are no longer wanted): "They don't work for claps and cheers on a Thursday evening, they work for remuneration commensurate with their experience".

Neil Barnard's analysis of why the NHS is in crisis maps out the underlying causes (austerity, underfunding, worsening of pay and working conditions) while also warning that "The NHS has relied on [the] goodwill bank [of staff] for years to keep the service running, and right now, it is running dangerously low on capital. Staff are leaving the NHS in droves" and to remind us all that "The question is not if we'll face another pandemic but when".

Rose Singleton's account of becoming a partner as a GP during Covid is summed up with her remarks that "The coronavirus pandemic has been a demonstration of the exact reasons I wanted to become a partner in the first place; to have some control and influence where I felt it mattered... Looking ahead, as the impact of coronavirus wanes, our group of partners can make our own decision about what we do in that future". Reflecting the note of hope, perhaps even a determination to remain optimistic, in the face of all the suffering and change the pandemic brought, which these accounts make repeatedly. The message of hope is again reinforced in the narratives about vaccination.

A range of international perspectives – with accounts from South Africa, Gaza, Australia, the USA and Singapore, far too many to detail greatly here – illustrate very well how the different healthcare systems, and the people charged with working in them, coped and their own take on how the NHS in the UK fared in comparison (the sheer hard work of staff in the UK is recognised, despite the government's shortcomings).

Ellie Philpott's account of health journalism during Covid (she works with GP and Pulse

magazines) offers a rare perspective into the challenges facing journalists during the pandemic but again ends on a note of hope: "Words jumped off screens and pages during the time of Covid, offering a supportive touch when touch in its normal format wasn't permitted; advice to the scared, newly hospitalised patient ... or a flash of hope in the form of arrival and implementation of the vaccination programme...It was and is powerful to have played some small role in all of that".

The short concluding chapter reminds us that Covid is not going away any time soon. It pays tribute to the efforts of NHS staff while also pointing out that the system was already broken by years of austerity, and the responses of the government were hardly 'world beating' in coping with Covid-19, as it wavered between ill-informed hope masquerading as policy over 'herd immunity' to complete lockdown, opening up again, failing to lock down soon enough, then having to impose total lockdown yet again. The book calls for the major inquiry promised but so far showing no sign of happening so that major decisions can be scrutinised to save lives the next time, not forgetting for one moment the need for answers for all those families who lost people.

"If millions can be siphoned into untried [and, as other books point out, almost certainly unworthy] ventures such as test and trace, then those in power can make choices to spend money on the areas of need within our health system" is a key point drawn in summing up, which is then explained further with tangible, concrete steps that can and should be taken to ensure that next time, the NHS can cope. A far cry from the groundless ideology which was all too often the hallmark of government actions during the pandemic.

This book is well worth reading, in bringing the pandemic into sharp focus with so many first-hand accounts.

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Interested in joining in more?

The Executive Committee welcomes new people who want to take a more active role in the group at any time and can co-opt members on to the EC. Please contact the Chair if you want to join.

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Would they have
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If you are a doctor, please join us. You will gain:

- A network of like-minded medical colleagues, many of whom have been campaigning against NHS cuts and privatisation for years. Doctors for the NHS is widely respected.
- Insight into how the cuts and privatisation are happening .
- More chances to act to save services locally and nationally, as membership facilitates coordination with other health campaigns.

